

FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

24432

3170

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since 6-5-47
(Specify whether
In this community 20 years
years, months or days)

3. (a) PRINT FULL NAME Dr. Jacob H. Weiner
3. (b) If veteran, name war World War #1
3. (c) Social Security No. 487-09-4733

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Myrtle Weiner
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased September 29 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 9 29 18 hr. min.

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Managing Director
Vet. Products, Inc.

11. Industry or business Vet. Products, Inc.

MOTHER FATHER

12. Name Henry Weiner
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Goldberg
15. Birthplace Russia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Myrtle Weiner
(b) Address 401 E. Armour, Kansas City, Mo.

17. (a) removal (b) Date thereof 7-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New York City, Penn. Sta.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Lincoln Plaza, K. C., Mo.

19. (a) 7-28-47 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 401 East Armour Boulevard
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 27
year 1947 hour 2:45 minute P. M.

21. I hereby certify that I attended the deceased from June 5, 1947 to July 27, 1947
that I last saw him alive on July 27, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
Due to thrombosis femoral veins
Due to

Other conditions Croupyema
(Include pregnancy within 3 months of death)
Fatty degeneration of heart

Major findings: Of operations
Of autopsy above 93d

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work?..... (e) Means of injury 0

23. Signature J. H. Hoffmann M.D. (M. D. or other)
Address 408 E. 9th St. Kansas City Mo Date signed 7/28/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. Blair Sheppard*
Licensed Embalmer No. *4179*
P. O. Address *K. C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.